



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MILLENNIUM CHIROPRACTIC

Respondent Name

DALLAS COUNTY HOSPITAL DISTRICT

MFDR Tracking Number

M4-17-1239-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The physical therapy services rendered on above dates of service were pre-authorized by the carrier (see enclosed pre-authorization letter). Approved by the insurance carrier and according the ODG guides, and MUST BE PAID."

Requestor's Supplemental Position Summary: "Dr. VanderWerff does NOT want to withdraw the dispute, and still wants an MDR decision made."

Amount in Dispute: \$2,558.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of sending additional payment to the provider. If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medical dispute resolution."

Response Submitted by: Flhavige, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2016	CPT Code 98943, G0283-GP, 97110	\$284.24	Not eligible for review
January 6, 2015 January 7, 2016 January 14, 2016 January 18, 2016 January 20, 2016 January 21, 2016 January 25, 2016 February 1, 2016	CPT Code 98943 Chiropractic Manipulation	\$50.00	\$0.00

January 6, 2016 January 7, 2016 January 14, 2016 January 18, 2016 January 20, 2016 January 21, 2016 January 25, 2016 February 1, 2016	CPT Code G0283-GP Electrical Stimulation	\$24.00	\$132.64
January 6, 2016 January 7, 2016 January 14, 2016 January 18, 2016 January 20, 2016 January 21, 2016 January 25, 2016 February 1, 2016	CPT Code 97110-GP (X4) Therapeutic Procedure	\$210.24	\$158.08
TOTAL		\$2,558.16	\$290.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.
 - 198-Payment denied/reduced for exceeded precertification/authorization.
 - 59-Processed based on multiple or concurrent procedure rules.
 - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
 - W3-Additional payment made on appeal/reconsideration.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for date of service January 4, 2016?
2. Does a preauthorization issue exist for CPT code G0283-GP?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed

on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of service in dispute is January 4, 2016. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on January 6, 2017. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute for this date with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for date of service January 4, 2016.

2. According to the explanation of benefits, the respondent originally denied reimbursement for CPT code G0283-GP based upon "198-Payment denied/reduced for exceeded precertification/authorization."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code G0283 is defined as "Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care."

Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning."

On December 22, 2015, WellComp gave preauthorization approval for ten (10) sessions of chiropractic/physical therapy services, CPT codes 98943, 97140, 97110, G0283, 97112 and 97116. Therefore, the respondent's denial is not supported.

3. The respondent indicated that additional reimbursement was issued to the requestor. To determine if the requestor is due additional reimbursement the division refers to 28 Texas Administrative Code §134.203.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

On the disputed dates of service, the requestor billed CPT codes 97010-GP, G0283-GP and 97110-GP (X4). CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in

office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.” The multiple procedure rule discounting applies to the disputed service.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061, which is located in Irving, Texas; therefore, the Medicare participating amount is based on locality “Dallas, Texas”.

The 2016 DWC conversion factor for this service is 56.82.

The 2016 Medicare Conversion Factor is 35.8043

Using the above formula and multiple procedure rule discounting policy, the Division finds the following:

Code	Medicare Participating Amount	MAR	IC Paid	Amount Due
98943	Not priced by Medicare	F&R	\$50.00 each date X 8 dates = \$400.00	\$0.00 *
G0283-GP	\$14.06	\$16.58	\$0.00	\$16.58 X 8 = \$132.64
97110-GP (X4)	\$32.85	\$158.08	\$158.08 each date X 4 for dates of service 1/6/16 through 1/18/16 = \$632.32; and \$118.56 each date X 4 for dates of service 1/20/16 through 2/1/16 = \$474.24 for a total of \$1,106.56	\$158.08 X 8 = \$1,264.64 minus \$1,106.56 = \$158.08

Because CPT code 98943 is not priced by Medicare the division refers to 28 Texas Administrative Code §134.203(f) which states, “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 Texas Register 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(f) which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

The requestor is seeking \$50.00 for CPT code 98943. A review of the submitted documentation finds that the respondent paid \$50.00. As a result additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$290.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$290.72 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	03/02/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.